The Report Committee for Won No
Certifies that this is the approved version of the following report:

Health Care Co-operatives in South Korea: an Effective Alternative to the Health Care System in the Future?

APPROVED BY
SUPERVISING COMMITTEE:

Supervisor:

David Warner

Christopher King

Health Care Co-operatives in South Korea: an Effective Alternative to the Health Care System in the Future?

by

Won No, B.P.Admin.; M.P.A.

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Dedication

This is dedicated to my beloved family…

Abstract

Health Care Co-operatives in South Korea: an Effective Alternative to the Health Care System in the Future?

Won No, MPAff

The University of Texas at Austin, 2013

Supervisor: David Warner

South Korea has been evaluated as having the weakest primary care system. In South Korea, the health care delivery system is concentrated too heavily in the private sector. Increased concern on keeping one's health and reducing the burden of health care costs led community members to gather and form health care co-operatives. Currently, 19 health care co-operatives have been established through residents' participation and even more are preparing to be incorporated.

As a nonprofit organization, a health care co-operative is a voluntarily established co-operative organization that tries to solve health, medical, and life problems in communities. This report examines how these health care co-operatives work in the health care system, whether they can be effective alternatives to a future health care system in South Korea, and finally the report provides recommendations.

Given the fact that the nation already has national health insurance, health care co-operatives in South Korea mainly operate several clinics by focusing more on managing chronic diseases and increasing access to care, rather than developing

affordable health care insurance or lobbying in policy sectors as they do in other countries.

Health care co-operatives' motivation is to keep people healthy; hence, they put a great deal of effort into delivering primary care and helping patients deal with chronic diseases. Health care co-operatives are encouraging because of their democratic structure. Health care co-operatives emphasize the idea that the owners of the health care co-operatives are in fact the members. The overall satisfaction of users in the current health care cooperatives is moderately high. Taking the lessons from the examples of health co-operatives in other countries, health care co-operatives should be able to function as a good complementary to the health care system.

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Chapter 1: Introduction

The constitution of the World Health Organization (1948) defines health not merely as the absence of disease or infirmity but as a state of complete physical, mental, and social well-being. In addition, the constitution of the Republic of Korea states that health also encompasses the right to live, a fundamental right of humans. From this viewpoint, health is not just a personal problem but one of the rights that a society needs to guarantee to its entire people.

Living standards are rising. People now pursue a better quality of life. Nevertheless, industrialized society is putting people at risk of exposure to hazardous substances. Overeating is putting people at risk of developing chronic disease. It is thus becoming more important to improve health and to prevent disease. Therefore, community health and health care service delivery have become even more important.

South Korea has a system for National Health Insurance (NHI). As of 2013, registration is compulsory and the coverage is universal. The first public mandated health insurance was introduced in 1977 for the large companies' employees. In 1989, health insurance had been extended to the entire population (Jones, 2010). The government office accountable for the health of the whole population and in charge of health insurance policy is the Ministry of Health and Welfare (MoHW). Under its supervision, the National Health Insurance Corporation (NHIC) manages the NHI program and its funds, by providing health care benefits to the population, collecting contributions, and reimbursing health care providers. NHIC, which is a nonprofit institution, is a single insurer that provides health insurance to all citizens. As a public corporation under the

direction of MoHW, the Health Insurance Review and Assessment Services (HIRA) reviews medical fees and evaluates the appropriateness of health care benefits that patients receive (Chang, Kim, Lee, & Lee, 2009).

The health care services and the existence of a compulsory NHI system in Korea make the system seemingly quite public. However, the health care delivery system of South Korea is concentrated very heavily in the private sector. The lion's shares (92%) of medical institutions are private but nonprofit. The government operates only a few public health centers and public hospitals (Chang et al., 2009). Currently in South Korea, allowing for-profit health care institutions has become a controversial issue. South Korean law prohibits any health care institution being established as a for-profit organization. Under the current law, the only entity that can open and operate a health care institution is a person holding a medical license.

Furthermore, among the Organization for Economic Co-operation and Development (OECD) countries, South Korea has been evaluated as having the weakest primary care system (Jeong & Sung, 2009). In 2005, the Roh's administration, to improve the primary care delivery system, promoted a plan to install one urban public health center per 50,000. Critics point out that these primary health care institutions tend to, instead of preventing diseases, repeat treatments of minor problems (Cho & Lee, 2004).

To pursue true "health care" that guarantees people's health status with no discrimination based on financial status, some have pointed to a need for community members to improve their environment and to establish a health care system (Lee, 1998). A typical example of this is the founding of health care co-operatives, with a number of them now emerging in South Korea.

Health care co-operatives are a source of encouragement because they are organized by community members to solve their own health problems in a community. They aim at putting efforts into preventing chronic diseases and helping people stay healthy. Currently, 19 health care co-operatives have been established in Korea by residents' participation and even more are in the works.

In South Korea, co-operatives are generally booming now. Answering society's needs, law makers made recent revisions in related law and regulations on co-operatives that heralded a watershed moment. Consequently, this report tries to answer the following questions.

- How do the health care co-operatives work in South Korea's health care system?
- Can establishing health care co-operatives be an effective alternative for South Korea's future health care system?
- What the implications can be found in the results and recommendations?

Chapter 2: Health Care Co-operatives in South Korea

HEALTH CARE CO-OPERATIVES

Definition of Health Care Co-operatives

Kofi Annan, at the United Nations International Day of Cooperatives in July 2003, had this to say about the co-operative movement.

> One of the largest organized segments of civil society, and plays a crucial role across a wide spectrum of human aspiration and need. Co-operatives provide vital health, housing and banking services; they promote education and gender equality; they protect the environment and workers' rights. Through these and a range of other activities, they help people in more than a hundred countries better their lives and those in their communities. (UN, 2003, p. 1)

According to the Health Co-operative Startup Guide in Canada, the four common characteristics of health co-operatives are 1) team-based medical practice, 2) preventive medicine, 3) periodic payment, and 4) consumer control (Co-operative Secretariat, 2008). Health care co-operatives, or "health co-ops," are voluntarily established co-operative organizations that aim to solve the health, medical, and life problems in their communities (Lee, 1998).

Membership

Health co-ops appear in various forms: consumer-driven, worker-owned, producer-owned, or multi-stakeholder model of governance in which serving on the board are consumers, workers, and community representatives (Girard, 2009). Most of the health co-ops are formed as multi-stakeholder co-operatives, as they have consumers, doctors, administrative staff, medical staff, and community leaders all together as their

member. Many community health co-ops adopt the multi-stakeholder model and have an open membership policy (Craddock, 2004).

Health co-ops emphasize the idea that the members are the owners of the health co-op. To be a member, a person should invest a certain amount; an amount is not regulated but decided on voluntarily by members. Once a person joins a health co-op, eligibility is extended to its entire household. Such a family member must be registered at the same address, or be listed on the same family certificate. Should a member want to leave, he/she can get a 100% refund of his/her investment—with no interest paid, as the health co-op is a non-profit/social enterprise (AnSan Health Co-op, n.d.).

Most of the health co-ops have been established under democratic structures, observing the Consumer Co-operative Act. First, the whole fund should be used for achieving the goals of its members. Second, the amount that one member invests cannot exceed 20% of the co-op's entire fund. Third, the health co-op provides equal rights and benefits to all. Every member has the right to participate in any activity the health co-op pursues. Its board members and representatives are elected by members. The members have the right to participate in the general meeting, the right to set forth their view, and the right to vote.

Health Care Co-operative as a Nonprofit Organization

What is a nonprofit organization? Quite simply, it is one not run with the aim of making a profit. The UN (2003) lays out the distinctive features of nonprofit organizations, which include health co-ops that merit their distinction as such:

- Not-for-profit character: A nonprofit organization may earn profits. However, the organizations are not organized for profit and cannot distribute the profits to their

staff such as directors or managers. Therefore, the objective functions of nonprofit organizations are different from those of for-profit firms.

- Public-goods production: Nonprofit organizations may also produce private goods to sell on the market; they often produce collective goods that are financed through other means such as charitable contribution, or volunteer effort.
- Governance structures: The structure of nonprofit organizations is not the same as either corporations or governmental units. Nonprofit boards are rarely paid and not publicly elected.
- Revenue structure: The revenue structure mainly includes important voluntary donations of time and money.
- Staffing: The staffing of nonprofit organizations often includes substantial numbers of volunteers.
- Capital sources: Nonprofit organizations cannot attract equity capital because they are not allowed to distribute profits.
- Tax treatment: Nonprofit organizations are typically exempt from several taxes, such as corporate income taxes, sales taxes, and property taxes.
- Legal treatment: Nonprofit organizations are typically subject to special legal provisions related to their revenues, their involvement in political activities, their reporting, and accounting standards.
- Lack of sovereign powers: Although they often receive substantial amounts of government financial support, they lack sovereign power, for example, compulsory powers over all those dwelling or carrying on activities within a given area.

The biggest difference between health co-ops from other health care organizations is that the health co-op members (residents and patients) work as the foundation of the organization, and are able to develop their own health-promoting activities. In other words, the health co-op does not internalize their members but lets them act as networkers between official and unofficial domains. In addition, their activities are not included in the framework of public health insurance. Therefore, the health co-ops are private, nonprofit, and official. In terms of structure, the health co-ops are closer to a community than other health care organizations (Hwang, 2004). Hwang (2004) emphasized that it is important for health co-ops to fulfill their missions in practice—promoting the health of members and community.

Moreover, South Korea's Basic Law on the Co-operatives was recently legislated, and it opened a better way for health co-ops in South Korea to be acknowledged in the legal system as a nonprofit organization. Details are discussed in Chapter 3.

History of Health Care Co-operatives in South Korea

The idea of health co-ops was started from the common belief that it is important not only to cure diseases but also to ensure people's health even when they are not ill. The members of health co-ops share the belief that health is not just an individual problem but a right that a society needs to guarantee for all people.

The health co-operative movement in South Korea began in 1975, as a part of the Blue Cross movement. The Blue Cross movement, started in Korea's second largest city, Busan, is well known as the first private medical insurance union in the country offered by churches, local residents, and healthcare providers. As the national health insurance system had yet to be established, the movement was aimed at alleviating excessive

medical costs for local residents by offering healthcare services, welfare services, and scholarship programs for low-income residents.

The Blue Cross hospital was a transitional type of private medical union, so AnSeong Health Co-op, established in 1994, is considered the first official health co-op. In 1987, a Christian students club in Medical School at Yonsei University started providing weekly volunteer medical services in three rural areas around AnSeong. Seven years of weekly medical clinic operation laid the groundwork for establishing the AnSeong Health Co-op.

Compared to the 1970s, when there was the first movement of the Blue Cross hospital without NHI, now it seems like Koreans have better access to health care with economic development and universal NHI. However, as the number of private health care institutions prospered, the more problems appeared. In the competitive market, many private health care institutions fight against excessive competition by increasing the number of patients they treat a day. Under the fee-for-service system, clinics need to treat more patients to earn profits. A study conducted a survey of doctors and found that the respondents treat in average 71.6 patients a day, and dedicate 51.1 hours, 6 days a week, for patient treatments in average (Im, Min, Choi, Lim, & Park, 2010). Working more than 40 hours a week is a breach of the Labor Standards Act, but it seemed inevitable for them to manage their own clinics. As a result, the average consultation hours shortened, and the quality of treatments lowered. In addition, the overdose of antibiotic was reported. In 2010, the average antibiotic prescribing rate of general clinics was 53.2% (Cha, 2012). The health co-op movement started from finding a way of avoiding those problems.

The Current State of Health Care Cooperatives in South Korea

South Korea's case differs from some health co-ops in other countries, co-ops organized so as to purchase health insurance at more affordable prices. Given the fact that all Korean citizens are eligible to register in its NHI system, the health co-ops try simply to secure better health care services.

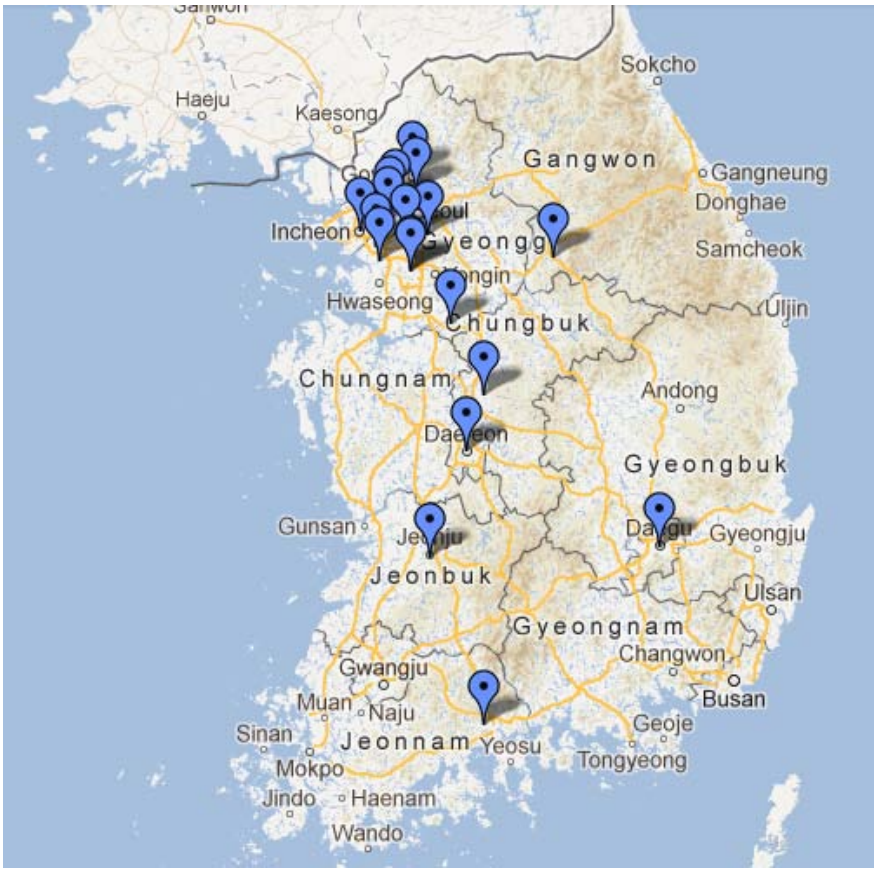
According to the MoHW, the number of health co-operatives exceeded 300 in 2012 (Kim, 2012). Only 19 of them, however, can be considered "true" health care co-operatives, which are the members of Korea Health Care Co-operative Federation: AnSeong health co-operative, Incheon *PyeongHwa* (Peace), health co-operative, AnSan health co-operative, WonJu health co-operative, DaeJeon *Mindeulle* (Dandellion) health co-operative, Seoul health co-operative, JeonJu health co-operative, *HamGge GeolEum* (Walking together) health co-operative, CheongJu *A-Ol* health co-operative, SeongNam health co-operative, SuWon *SaeNal* (New Day) health co-operative, SiHeung *HeeMang* (Hope) health co-operative, *OlBaReun* (upright) health co-operative, MaPo health co-operative, *SalLim* (Life) health co-operative, *HaengBokHan MaEul* (Happy Village) health co-operative, *HanGyeoRae DuRae* (One people together) health co-operative, SunCheon health co-operative, and DaeGu *SiMin* (Citizen) health co-operative (Shin, Lee, & Yoo, 2012).

Figure 1 shows from Google Maps (2013) the locations in South Korea of the registered health co-ops. Only 7 of the 19 health co-ops are located outside the Seoul metropolitan area. This means that a majority of the health co-ops serve people living in a big city.

Aside from these 19 health co-ops, the rest listed with MoHW are not legitimate. Those health co-ops are exploiting the loophole in between the Medical Act and Consumer Co-operative Act. Although the Medical Act regulates the owner of a health

institution to be a medical professional, it is legitimate to establish a health co-op without holding a medical license because a health co-op is one of the co-operatives that are regulated under the Consumer Co-operative Act. Therefore, anyone who has enough money to invest can be a director of a health co-op and he/she can simply hire a doctor as an owner of the health clinic in the health co-op. They make a forged list of members and disguise themselves as health co-ops but in fact, they pursue their own profits not the public interest of the community members (Ahn, 2012).

Figure 1: Distribution of Health Care Co-operatives in South Korea



Note. From Google Maps. Copyright 2013 by Google. http://goo.gl/maps/TIXDg

Table 1: Registered Health Co-ops in South Korea in 2013

Name	Medical Services	Year	Members (Household)
AnSeong health co-operative	3 western general clinics, 2 oriental medicine clinics, a home nursing care center, a dental clinic, a health examination center, & a long-term home health care agency	1994	4,823
Incheon *PyeongHwa* (Peace) health co-operative	a western general clinic, an oriental medicine clinic, a home nursing care center, & a health examination center	1996	3,501
AnSan health co-operative	a western general clinic, an oriental medicine clinic, & a health examination center	2000	5,624
WonJu health co-operative	a western general clinic, an oriental medicine clinic, a care giver education center, & a long-term home health care agency	2002	2,486
DaeJeon *Mindeulle* (Dandellion) health co-operative	a western general clinic, an oriental medicine clinic, a dental clinic, & a long-term home health care agency	2002	3,240
Seoul health co-operative	an oriental medicine clinic, a dental clinic, & a long-term home health care agency	2002	2,665
JeonJu health co-operative	an oriental medicine clinic, & a long-term home health care agency	2004	767
HamGge GeolEum (Walking together) health co-operative	an oriental medicine clinic, & a home long-term care agency	2005	1,108
CheongJu *A-Ol* health co-operative	a western general clinic	2007	629
SeongNam health co-operative	an oriental medicine clinic	2008	1,787
SuWon *SaeNal* (New Day) health co-operative	an oriental medicine clinic	2009	811

Table 1 (Continued)

SiHeung *HeeMang* (Hope) health co-operative	an oriental medicine clinic , a dental clinic (under preparation)	2009	900
OlBaReun (upright) health co-operative	a rehabilitation clinic	2011	634
MaPo health co-operative	a western general clinic (under preparation)	2012	420
SalLim (Life) health co-operative	a western general clinic	2012	1,026
HaengBokHan MaEul (Happy Village) health co-operative	a western general clinic (under preparation)	2012	389
HanGyeoRae DuRae (One people) health co-operative	a western general clinic (under preparation)	2012	350
SunCheon health co-operative	a western general clinic, a oriental medicine clinic, & a dental clinic (all under preparation)	2012	300
DaeGu *SiMin* (Citizen) health co-operative	a western general clinic (under preparation)	2012	340

Note. updated from Shin, H., Lee, S., & Yoo, H. (2012). *Healthcare delivery reform for reducing health inequality*. Seoul. Korea Institute for Health and Social Affairs.

Two Examples of Health Care Co-operatives in South Korea

AnSeong Health Care Co-operative

AnSeong is a small, urban-rural city complex of approximately 185,000 people including about 7,000 foreigners (AnSeong City Government, 2012). Its main industries are agriculture, ranching, and manufacturing. AnSeong Health Co-op was first established in 1994. As of 2012, the AnSeong Health Co-op consisted of three general clinics, two oriental medicine clinics, a dental clinic, a health examination center, and a long-term home health care agency. It has been 18 years since they opened, and now it serves approximately 4,800 households with 15 doctors, and a staff of 107 (including nurses, physical therapists, care workers, and administrative staffs). Members comprise nearly 10% of the whole population of AnSeong (Kim, 2013).

The health co-op encourages members to be engaged in the organization in various ways such as joining committees, clubs or volunteer programs. All the activities help members promote healthy living in the community. Members can serve on several committees: healthy village committee, the head office utilization committee, management committee, education/PR committee, etc. A number of clubs are also available, for example, studying Japanese, English, or co-operatives; philosophical clubs investigating the meaning of life, death, and happiness; as well as dancing or sports clubs. Moreover, AnSeong Health Co-op provides a "Volunteer Manual" annually to help their members find a best-fit volunteer program. In 2011, various volunteer programs were operated, such as providing rides to the elderly who have suffered strokes, assisting health examination services, repairing houses for low-income families, assisting oriental medicine clinic services, assisting publishing and sending out the co-op newsletters.

AnSan Health Care Co-operative

AnSan is a mid-sized city of approximately 760,000. Ansan was developed as a part of a plan intended to disperse the population in the Seoul metropolitan area. The first meeting to promote the establishment of a health co-op in AnSan city was held in May 1999, and an initiative was announced in October 1999. In the five-month interim, backers prepared to establish the health co-op through several meetings. For example, they arranged information meetings to share knowledge about co-operatives, and had a training trip to Japan. AnSan Health Co-op set Japanese health co-ops as its benchmark.

After 10 years of operation, AnSan Health Co-op obtained the "social enterprise" certification from the Ministry of Employment and Labor. The benefit of being certified as a social enterprise is becoming eligible to receive various types of support from the government. As most of social enterprises lack administrative resources, the first thing

the government subsidies went to were consulting services in management, accounting, taxation, and personnel management. Second, a social enterprise is entitled to a 50% reduction on corporate tax and revenue tax. Third, the government may subsidize a part of the four social insurances such as unemployment insurance, national pension, occupational health and safety insurance, and national insurance that the enterprise must cover (Kang, 2011).

As of 2012, AnSan Health Co-op was operating a general clinic, an oriental medicine clinic, a dental clinic, a nursing home, a home nursing care center, a home long-term care agency, and a health examination center.

Managing Health Care Co-operatives in South Korea

Establishing a health co-op became more difficult since December 2012 as the new Basic Law on the Co-operatives came into effect. In the past, a co-op had to have at least 300 members and 30 million Korean Won (KRW; approximately US$28,000) for an initial investment to be authorized by the local government. In order to prevent emergences of disguised health co-ops, MoHW tightened the initial requirement, under the Basic Law on the Co-operatives, to have at least 500 members and one hundred million KRW (approximately US$91,000) in order to incorporate a health co-op (Kim, 2012).

All the health co-ops in South Korea operate their own health clinics or now prepare to construct one, which may be Western, Oriental, or dental. As there are no regulation on the number or the type of clinics that a health co-op should own, the promoters, on the preparation stage, decide through the meetings what kind of clinics they are going to operate, under the consideration of the needs and the concerns in the

community. Once a health co-op decides the type of clinic to operate, then they register to the local government and the government needs to approve the registration. With the current health clinics that these co-ops have, such as general clinics, oriental medicine clinics, and dental clinics, they are unable to provide secondary or tertiary care. However, the family doctors in the health co-ops introduce and recommend appropriate health care institutions for the patients in need.

In terms of management, health clinics in a health co-op are not much different from other clinics in general. It is because health clinics are classified as a clinic in the overall health system, even though they are owned by a health co-op. As the patients are all registered to NHI, the health co-op clinics get payments from the patients and reimbursements from NHIC by fee-for-services system. All medical staffs such as physicians and nurses are hired full-time by the health co-op.

Health co-ops' clinics, however, have been provided a number of services for the sake of communities. First, visiting a clinic is less expensive for a patient, because the co-insurance rate of a clinic is lower than that of a general hospital. While the co-insurance rate for the medical fees of a clinic is 30%, and that of a general hospital is up to 50% (HIRA, 2011). Second, health co-ops try to provide their services at affordable costs. It is possible because the health co-ops' clinics decides their medical fee through regular meeting by taking account of their concerns on communities. For example, WonJu Health Co-op set much lower price, compared to other clinics, for some necessary infant vaccination shots which are not covered by NHI (Cha, 2012). Third, in the first half of 2010, antibiotic prescribing rates of health co-ops' clinics were from 5.9% to 20.5%, which was much lower than the average of clinics nationwide, 53.2% (Cha, 2012).

One of the challenges the health co-ops' clinics have is reaching their break-even point to be sustainable. There are some health co-ops, primarily those opened during the

last decade, start their operation with oriental medicine clinics and dental clinics, not clinics with a general practitioner. This is because it is common for co-ops to lose money running a general clinic, as NHI covers most of the diseases that a general clinic deals with. When NHI treats a disease, the clinic can only claim certain fees as regulated by NHI. It is more profitable to treat patients suffering from illnesses or diseases not covered by NHI since these costs are adjustable by clinics. It is pointed that the adjustment of medical fee plan is needed (Im et al., 2011). Under the current system, in order to stay without deficit, the health co-ops should increase the average number of patients they treat a day. It is, however, against what they initially aimed at. Therefore, the Health co-op clinics can make a breakthrough by focusing on the fact that they get periodic payment from members. The break-even point of a health co-op is considered having 2,000 households as members. There are 6 health co-ops which serve more than 2,000 households joined as members, and they all have more than 10 years of history. Except one of the six, Seoul Health Co-op, all the five health co-ops run more than one general clinics. Therefore, it can be pointed out that a health co-op needs some time to be implanted in a community.

Second, health co-ops face another challenge of hiring qualified medical staff. The doctors need to have a strong sense of duty to work in a health co-op. It is difficult to hire such doctors because health co-ops cannot pay as much as other private hospitals and clinics can. However, as more successful stories of health co-op clinics spread out, the more doctors have a good feeling toward health co-op clinics as their workplace. When the doctors join a health co-op, they have less stress on managing a clinic than before, because the health co-op members share ownership. Sharing ownership allows doctors to concentrate more on promoting the health of the members and residents of a community (Kim, 2012).

Chapter 3: Related Law and Regulation

LAW AND REGULATION RELATED TO HEALTH CARE CO-OPERATIVES

Consumer Co-operative Act

Revision of Consumer Co-operative Act

The Consumer Co-operative Act was amended in 2010. This was done to reflect a more contemporary society that had changed tremendously since 2000 when the original act was passed. The New Consumer Co-operative Act aims to promote the consumer co-operatives' independent, self-reliable, and autonomous activities. Several parts affect health care co-operatives.

Article 11 (Relations with Other Acts)

In the new Consumer Co-operative Act, Article 10 states that this Consumer Co-operative Act takes priority over other related acts in terms of public health and health care services. The original act did not regulate the relations between the Medical Act or other related laws; in fact it stirred up controversy in the operation of health co-op clinics. From the time the AnSeong Health Co-op was first established, for example, it was unclear whether a health co-op clinic was allowed, even in an emergency, to treat non-member patients. On the one hand, according to Article 16 in the Medical Act, a health care provider should not refuse to treat an emergency patient without having a special reason. On the other hand, under the Consumer Co-operative Act at that time, only members of a co-op could enjoy its benefit. In addition, many laws related to health care affected the operation of health co-op clinics.

The newly amended Consumer Co-operative Act is encouraging. It clarifies the relations between the acts. Under the enforcement regulations, however, lawmakers need to elaborate with more specific points. That is because the Consumer Co-operative Act intends health co-ops to provide their ordinary services only to their members, but to not turn away emergency patients. Article 46 specifies the exemption for health co-ops.

Article 46 (Use of Services)

The "members-only" rule is the fundamental principle of every co-operative. Article 46, Section 1 in the new Consumer Co-operative Act states that any co-operative should not provide services to non-members. This is compulsory, ensuring the value and fulfilling the philosophy behind co-operatives.

The most important section is Section 3, which stipulates that health co-ops can provide their services to non-members under the 50% number of its whole beneficiaries. Under the former Consumer Co-operative Act, the providing of medical services to non-members was prohibited, as no exemption existed for the "members-only" rule. As mentioned above, Article 16 states that a health care provider cannot refuse treatment when it is requested during an emergency or in premature birth. Indeed, in such instances the health care provider should provide its best possible service. In addition, the Emergency Medical Service Act guarantees all in the nation has the right to receive emergency treatment without sexual, age, ethnical, religious, social, or financial discrimination. Therefore, out of due respect to all human life, health co-op clinics may provide emergency treatment even to non-members.

Nevertheless, the 50% rule is applied with no regard to the various statuses of each health co-op. In fact, the number was simply established by benchmarking Japan's Consumer Co-operative Act (Park, 2010). The enforcement regulation, which is an

ordinance of the Prime Minister, includes the exemption rule that is applied to three groups of people: (1) emergency patients under the Emergency Medical Service Act, (2) recipients under the National Basic Living Security Act, and (3) a person who lives or works in the area around a health co-op.

Article 50 (Allocation of Surplus)

Every co-operative is allowed to allocate its surplus after restoring its losses and keeping its legal reserve. Under the New Consumer Co-operative Act, however, health co-ops are exempted from this section. Health co-ops are not allowed to allocate its surplus to members. The section is meant to prevent any possibility of viewing health co-ops as profitable enterprises.

A controversy exists over whether health co-ops are allowed to distribute their surplus among their members. First, the exemption was made because of the increasing trend of pseudo health co-ops. The main reason for pseudo health co-ops existing is, some have pointed out, the possibility of earning and distributing profits. Second, if a health co-op allocates its surplus based on the frequency of use, as other co-operatives allocate by performance and contribution of members, then it may be misconstrued that health co-ops encourage people to be sick. Third, when an allocation is allowed, health co-op members could benefit from non-members' frequent use. Park (2010) contended that the exemption of the allocation provision should be revised after health co-ops are more settled within the system.

Article 81 (Supervision)

In Article 81, Section 3, a Mayor or Governor has the power to order, when a co-op seems to have violated the Medical Law, an investigation of said co-op. The Mayor or Governor can command the health co-op to report on its services and properties, and has

the right to direct a government official to inspect all the related documents such as account books or business logs. According to Article 81, Section 7, Fair Trade Commission (FTC), the Mayor, or the Governor can contract out the inspection work to the National Health Co-op Association. The original Consumer Co-operative Act had no related provisions about supervision. The amended Act intends to prevent violations by pseudo health co-ops.

Article 82 (Cancellation of Permit)

To be established, a co-operative must obtain a permit. The original Consumer Co-operative Act offered no provisions related to the cancellation of establishment permits. However, in the new Consumer Co-operative Act, Article 82, Section 1, the mayor or governor may cancel a permit when a health co-op violates certain provisions under the Medical Act. In addition to notifying the FTC, the mayor or governor must announce the cancellation directly following the violation. Since the health co-op deals with health care, which is regulated by Medical Act, it is regulated by both the Consumer Co-operative Act and the Medical Act.

The Basic Law on the Co-operatives

In 2012, Korean lawmakers passed the Basic Law on Co-operatives. The law, which regulates the establishment and operation of co-operatives, is meant to contribute to the balanced development of the national economy and social integration and to promote co-operatives' independent, self-reliable, and autonomous activities. Many health co-ops are preparing to switch their status from co-operative to social co-operative. One of the special characteristics of the Basic Law on the Co-operatives is that it allows co-operatives to achieve the legal status of a nonprofit corporation. A co-operative is a

form of corporations; but it differs from a for-profit corporation because a co-operative emphasizes public value and responsibility to society (Center for Social Economy, 2012). The Korean legal system, however, has thus far admitted as nonprofit corporations only schools, hospitals, welfare facilities, and religious organizations. Co-operatives were barred from being considered nonprofit corporations because the only factor of determination was the purpose of establishment, not the actual management. The best status a co-operative could attain was "social enterprise," available after the Social Enterprise Act was passed in 2007 (Center for Social Economy, 2012). The Basic Law on the Co-operatives, however, engendered a big change; it enables a co-operative to achieve "social co-operative" status.

Benefits of Being a Social Co-operative

The main difference between a "co-operative" and a "social co-operative" (Table 2) is that the government requires social co-operatives to serve communities more so than normal co-operatives. Both the co-operative and social co-operative have the same standards for their operations and processes. To be established, they both need at least five people and be based on the "one member, one vote" principle. Social co-operatives, however, have to provide more than 40% of its whole services as public services. According to Article 93 of the Basic Law on the co-operatives, a co-operative can become a social co-operative if it performs 40% of its services (1) to promote the local economy, (2) to provide job opportunities for indigent people, or (3) as programs that are contracted by the government (Lee, 2012).

Table 2: Comparison of Co-operative and Social Co-operative

	Co-operative	**Social Co-operative**
Purpose	Promoting members' profit	Promoting members' profit and welfare of community residents and indigent people
Service Boundary	Service boundary is not restricted	Service boundary is not restricted / 40% of its main services should be - Promoting community's welfare - Hiring socially disadvantaged class - Contracted out from government - Other related to public interest
Establishment	Report to the mayor/governor	Obtain a permit from central administrative agency
Distribution	Allocate, based on performance and investment fund	Allocation prohibited
Benefit	None	Considered as nonprofit corporate, tax exempt
Accumulation	Save 10/100 of surplus	Save 30/100 of surplus
Supervision	None	Possibility of government supervision
Liquidation	Accord to articles of association	Restore remained assets to the state fund, etc.
Legal Status	Corporate	Nonprofit Corporate

Note. From Center for Social Economy. (2012, Nov 29). The guide on the basic co-operative act, (6) what makes social co-operative different?

When a group of people wants to establish a social co-operative, it may obtain a permit from the chief of the related central administrative agency, not having to report to the mayor or the governor of the region, as they did beforehand. As it is required to get a permit, social co-operatives are automatically subject to supervision from the

administrative agency. Moreover, social co-operatives should accumulate 30% of its surplus fund, not the 10% a co-operative does. When a social co-operative liquidates, the remaining assets have to be restored to the state, kindred organizations, or other associations. The biggest benefit for a “social co-operative” compared to a “co-operative” is achieving “nonprofit corporation” status, making the social co-operative eligible to receive tax exempt status (Center for Social Economy, 2012)

Chapter 4: User Satisfaction on Health Care Co-operatives

SATISFACTION OF MEMBERS, NONMEMBERS, AND NONUSERS

Survey: Patient Awareness of Health Care Delivery System

The Korea Institute for Health and Social Affairs conducted surveys, in 2009 and 2012. These went into the research reports: 2009-01, "Establishing an Integrated Health Delivery System: For Enhanced Quality and Effectiveness of Health Services" and 2012-08 "Health care delivery reform for reducing health inequality." The raw data was provided and it is analyzed in this report.

For the surveys, the institute selected five health co-ops from around the country. These were located in: AnSeong, InCheon, DaeJon, WonJu, and AnSan. The survey respondents were patients who had, over a six-month period each year, visited the health co-op clinics or general hospitals. In the first survey, 988 people were selected out of three groups, co-op members (388), nonmembers (104), and people with no experience with health co-ops—called as nonusers in this report (500). The third group, people with no experience with health co-ops was selected to compare the services of health co-ops to other hospitals in general. In the second survey, only people with experience were invited to participate; 514 people answered—313 co-op members and 201 nonmembers. The second survey aimed at analyzing health co-ops only, without comparison to other hospitals in general.

In this report, questions were selected to explain what health co-op members, non-members, and nonusers thought about the overall quality of services and family doctors of the health co-ops and other hospitals in general.

Demographic Characteristics

Table 3 shows the demographic characteristics of survey respondents. In the first survey (2009), the number of participants based on their regions was AnSan, 94 (19.26%), AnSeong, 94 (19.26%), InCheon, 100 (20.5%), Daejon, 100 (20.5%), and WonJu, 100 (20.5%). In the second survey (2012), the distribution was AnSan, 122 (23.7%), AnSeong, 123 (23.9%), InCheon, 99 (19.3%), Daejon, 80 (15.6%), and WonJu, 90 (17.5%).

The demographic characteristics of survey respondents do not represent the arrangement of all the health co-ops. However, it is a fact that the co-operatives consist mostly of 30- to 59-year-olds. The 2012 sample included more women and people of low education than did the 2009 sample.

Table 3: Demographic Characteristics of Survey Respondents

	2009			2012	
	Member	**Nonmember**	**Nonuser**	**Member**	**Nonmember**
Age					
19~29	7.0%	12.5%	20.2%	4.5%	10.0%
30~39	32.9%	26.0%	22.4%	13.1%	13.9%
40~49	30.5%	26.0%	23.0%	32.0%	22.9%
50~59	11.7%	13.5%	15.6%	26.2%	22.4%
60~69	13.3%	9.6%	18.8%	11.8%	13.4%
over 70	4.4%	12.5%	0.0%	12.5%	17.4%
Sex					
Male	49.0%	45.2%	49.8%	30.7%	34.3%
Female	51.1%	54.8%	50.2%	69.3%	65.7%
Marital Status					
Single	14.2%	19.4%	21.9%	8.0%	13.9%
Married	80.3%	70.9%	71.8%	80.2%	72.1%

Table 3 (Continued)

Separated	0.5%	1.0%	60.0%	11.8%	13.9%
Divorced	1.8%	2.9%	0.6%		
Bereaved	3.2%	5.8%	5.0%		
Education					
Uneducated	0.8%	1.0%	5.1%	12.5%	14.4%
Elementary	6.6%	11.7%	10.0%		
Middle school	5.8%	8.7%	7.6%	12.5%	15.4%
High school	39.7%	35.0%	37.9%	33.9%	40.8%
Two-year college	13.8%	15.5%	11.9%	41.2%	29.4%
Four-year college or above	33.3%	28.2%	27.5%		

Visiting Characteristics

The results of the survey show that health co-op members deal with their health problems in more desirable ways. More often than non-members they have their own family doctors. Members tend to get fewer unnecessary repeated treatments; they are more likely to feel their doctors discuss the checkup results further with them; and they think their doctors better understand their needs. The overall satisfaction with health care delivery in health co-ops was higher among members than among non-members.

Based on the survey results, health co-ops can, in various ways, improve their services (Table 4). Clinic visits were caused most often by slight illnesses, such as colds. However, the vision of health co-ops is to focus more on managing chronic diseases. It is encouraging that the number of people who visit their doctors because of chronic diseases increased 6.6% among members and 13.4% among non-members. In addition, both members and non-members still feel difficulty in paying for their health care costs and choosing appropriate health care institutions. Health co-ops can contribute by providing inexpensive health care services and, for patients needing special care, directing them to the appropriate hospital or dinic.

Table 4: Results on Visiting Characteristics

	2009			2012	
	Member	**Non-member**	**Non-user**	**Member**	**Non-member**
For what reason did you visit the hospital/clinic?					
Acute Diseases	37.9%	30.1%	36.6%	40.3%	28.9%
Chronic Diseases	21.8%	16.5%	20.8%	28.4%	29.9%
Medical Checkup	13.3%	13.6%	13.0%	14.1%	9.0%
Nursing /Care service	-	-	-	0.6%	3.0%
Other	27.1%	39.8%	29.6%	16.6%	29.4%
How do you usually select a doctor?					
Consult my family doctor	46.4%	34.6%	-	43.1%	34.8%
Collect information on doctors by myself	11.2%	14.4%	-	12.8%	9.5%
Visit the nearest hospital/clinic	35.7%	47.1%	-	40.0%	51.7%
Other	6.8%	3.8%	-	4.8%	3.5%
In order to get treatment, how difficult is it for you to travel to the hospital/clinic?					
Always difficult	1.6%	1.9%	-	1.0%	3.5%
Difficult	9.2%	9.6%	-	8.6%	9.5%
Somewhat difficult	38.5%	36.5%	-	23.0%	27.4%
Not Difficult	31.1%	35.6%	-	35.1%	34.8%
Not Difficult at all	19.5%	16.3%	-	32.3%	24.9%
During the last 6 months, do you think you have received the medicines you needed?					
Always	9.6%	6.7%	-	17.8%	11.6%
Often	37.1%	40.4%	-	44.8%	43.4%
Sometimes	28.3%	31.7%	-	20.5%	26.6%
Rarely	12.0%	9.6%	-	13.1%	16.2%
Never	1.6%	1.9%	-	3.9%	2.3%
When you visited a hospital/clinic, did you think the medical staff repeated unnecessary examinations?					
Always	1.1%	17.3%	-	0.7%	0.6%
Often	6.6%	16.3%	-	3.3%	8.1%
Sometimes	13.0%	41.3%	-	11.7%	10.9%
Rarely	44.7%	22.1%	-	35.5%	42.0%
Never	30.3%	2.9%	-	48.7%	38.5%
After getting a checkup, did the medical staff discuss the results with you?					
Always	23.6%	12.7%	-	40.9%	21.7%

Table 4 (Continued)

Often	46.7%	52.9%	-	47.3%	56.0%
Sometimes	11.4%	6.9%	-	5.3%	11.4%
Rarely	6.4%	10.8%	-	5.3%	9.2%
Never	1.3%	2.0%	-	1.1%	1.6%
During the last 6 months, did you think the medical staff clearly understood what you wanted?					
Always	12.3%	2.9%	32.1%	20.1%	14.4%
Often	63.9%	66.0%	41.4%	58.8%	60.2%
Sometimes	19.0%	22.3%	22.7%	16.9%	19.4%
Rarely	3.7%	7.7%	2.8%	3.5%	5.5%
Never	1.1%	1.0%	1.0%	0.6%	0.5%
Did the medical staff seem not to know about the treatment you had received from other hospitals/clinics?					
Always	3.1%	5.3%	11.7%	3.8%	3.0%
Often	32.9%	29.8%	26.6%	34.8%	34.3%
Sometimes	24.5%	26.6%	29.4%	24.9%	19.9%
Rarely	30.1%	30.9%	22.1%	25.6%	35.3%
Never	9.4%	7.5%	10.2%	10.9%	7.5%
Do you think you always receive the health care services that you needed?					
Always	18.0%	11.7%	23.2%	30.0%	22.9%
Often	43.0%	39.8%	28.0%	44.7%	39.8%
Sometimes	25.7%	28.2%	35.4%	19.2%	24.9%
Rarely	8.2%	13.6%	10.6%	4.8%	6.5%
Never	1.1%	1.0%	1.4%	0.3%	6.0%
Why do you think you could not get the health care service that you needed?					
Financial burden (health care cost)	42.9%	50.0%	41.7%	-	-
Difficult to travel to a hospital/clinic	7.1%	0.0%	18.3%	-	-
Do not know where to go	35.7%	25.0%	13.3%	-	-
Other	14.3%	25.0%	26.7%	-	-
Have you been satisfied with the treatment you have received during the last 6 months?					
Always	14.6%	9.6%	-	27.2%	15.9%
Often	53.3%	41.3%	-	50.5%	56.7%
Sometimes	28.7%	44.2%	-	21.4%	22.9%
Rarely	2.9%	3.8%	-	1.0%	3.5%
Never	0.5%	1.0%	-	0.0%	1.0%

Table 4 (Continued)

During the last 6 months, have you felt discontented with the treatment you've received?					
Always	1.1%	0.0%	3.0%	1.6%	0.5%
Often	6.9%	6.7%	9.0%	2.9%	5.5%
Sometimes	24.1%	34.6%	23.2%	16.3%	14.9%
Rarely	41.5%	38.5%	35.0%	46.3%	48.8%
Never	26.5%	20.2%	29.8%	32.9%	30.4%

Satisfaction with the overall quality of service was moderately high and highest among members. In the 2009 survey, 64.1% of members were "always" satisfied and 50.9% of non-members "often" satisfied. About 28% of members said they were only "sometimes" satisfied, compared to 44.2% of non-members. Those who were "rarely" or "never" satisfied with services consisted only of 3.4% of members and 4.8% of non-members. When they were asked to limit their response to medical treatment, 26.5% of members and 20.2% of nonmembers answered they were "never" discontented, and 41.5% of members and 38.5% of nonmembers said they were "rarely" discontented. Those people with no experience with co-ops were slightly more satisfied other hospitals/clinics than non-members but less than co-op members.

The patterns found in the 2012 survey bore similarities to those found in the 2009 survey. In an encouraging sign, the overall satisfaction with health co-ops had increased; 77.7% of members and 72.6% of non-members were "always" and "often" satisfied; 21.4% of members said they were "sometimes" satisfied versus 22.9% of non-members. Only 1% of members and 4.5% of non-members responded they were "rarely" or "never" satisfied with the service. When they were asked to limit their response to medical treatment, 32.9% of members and 30.4% of nonmembers answered they were "never" discontented. While 46.3% of members and 48.8% of nonmembers said they were "rarely" discontented.

Table 5: Results on Family Doctor Section

	2009			2012	
	Member	**Non-member**	**Non-user**	**Member**	**Non-member**
Do you have a family doctor?					
Yes	70.6%	46.0%	48.0%	48.6%	34.8%
No	29.4%	54.0%	62.0%	51.4%	65.2%
How often do you get treatment from your family doctor/doctor you regularly visit?					
Always	33.5%	7.1%	-	39.1%	30.6%
Often	55.4%	29.2%	-	47.0%	55.6%
Sometimes	5.8%	3.5%	-	6.0%	5.6%
Rarely	4.7%	7.1%	-	6.0%	5.6%
Never	0.7%	0.0%	-	2.0%	1.4%
Do you feel comfortable talking about your individual concerns with your family doctor(s) you regularly visit?					
Always	31.5%	4.4%	51.6%	43.1%	27.8%
Often	53.3%	25.7%	25.3%	45.7%	55.6%
Sometimes	12.7%	15.0%	17.4%	9.3%	8.3%
Rarely	2.2%	0.9%	5.3%	2.0%	5.6%
Never	0.4%	0.9%	0.5%	0.0%	1.4%
Does your family doctor know you well and your family's medical history?					
Always	16.4%	0.9%	30.0%	17.5%	11.4%
Often	48.4%	17.7%	29.5%	50.3%	51.4%
Sometimes	17.8%	11.5%	20.5%	16.1%	10.0%
Rarely	12.0%	9.7%	14.2%	12.8%	20.0%
Never	3.3%	2.7%	4.7%	3.4%	5.7%
When you need any examination/surgery/prescription, does your family doctor include you in the decision making process?					
Always	24.2%	6.3%	40.6%	29.5%	26.8%
Often	56.2%	81.3%	37.8%	55.0%	56.3%

Table 5 (Continued)

Sometimes	10.9%	12.5%	12.8%	11.4%	8.5%
Rarely	6.0%	0.0%	6.7%	3.4%	7.0%
Never	2.6%	0.0%	2.2%	0.7%	0.0%
Has the family doctor you regularly visit introduced you to other health care organizations or welfare facilities?					
Yes	33.8%	12.4%	-	35.8%	25.4%
No	66.2%	32.7%	-	64.2%	74.7%
What kind of organization/facility was it?					
Hospital/clinic	71.8%	12.4%	-	-	-
Pharmacy	11.0%	0.9%	-	-	-
Nursing home	4.5%	0.0%	-	-	-
Community welfare center	3.6%	0.0%	-	-	-
Rehabilitation facility	9.1%	0.9%	-	-	-
Other	0.0%	0.9%	-	-	-
Satisfaction with accessibility (distance)					
Very satisfied	35.1%	8.8%	-	44.4%	30.0%
Satisfied	41.0%	19.5%	-	36.4%	37.1%
Somewhat satisfied	19.9%	14.2%	-	15.9%	20.0%
Not satisfied	3.0%	1.8%	-	2.0%	8.6%
Not satisfied at all	1.1%	1.8%	-	1.3%	2.9%
Satisfaction with health care cost					
Very satisfied	33.0%	54.9%	-	32.5%	18.6%
Satisfied	44.0%	8.0%	-	53.0%	55.7%
Somewhat satisfied	18.3%	14.2%	-	13.3%	22.9%
Not satisfied	3.3%	21.2%	-	1.3%	1.4%
Not satisfied at all	1.5%	1.8%	-	0.0%	0.0%
Satisfaction with waiting time					
Very satisfied	19.1%	3.5%	-	18.5%	10.0%

Table 5 (Continued)

Satisfied	48.9%	12.4%	-	50.3%	51.4%
Somewhat satisfied	26.8%	22.1%	-	23.8%	31.4%
Not satisfied	2.6%	7.1%	-	5.3%	4.3%
Not satisfied at all	2.6%	0.9%	-	2.0%	1.4%
Satisfaction with the treatment time					
Very satisfied	-	-	-	29.8%	11.4%
Satisfied	-	-	-	53.0%	64.3%
Somewhat satisfied	-	-	-	16.6%	20.0%
Not satisfied	-	-	-	0.7%	1.4%
Not satisfied at all	-	-	-	0.0%	1.4%

Family Doctor

The survey questions were slightly changed in 2012. Survey participants in 2009 were asked to remember whether they had either a family doctor or a doctor they often visited. In 2012, however, all the questions were changed to use only the term "family doctor." This may have caused the drastic decrease, from 70.6% to 48.6%, in participants answering whether they had a family doctor. People may have had a doctor they often visited but didn't consider a family doctor.

Comparing the experiences with family doctors of co-op users (members/non-members) to those of non-users (Table 5), it is hard to state that health co-ops provide distinguishable "family doctor" services. First, the satisfaction on the physical accessibility, health care cost, waiting time was only asked of the co-op users. Second, looking at the questions about family doctors' awareness of one's medical history and one's comfort level communicating with the family doctor, the result shows a similar pattern of positive answers.

It is still encouraging that a health co-op receives a better evaluation for family doctors. In the 2009 survey, 35.1% and 41% of members said they were “always” and “often” satisfied with the accessibility. In the 2012 survey, 44.4% and 36.4% of members answered they were “always” and “often” satisfied with the accessibility, and 64.1% of members and 50.9% of non-members were “always” and “often” satisfied. There was large growth in the percentage of satisfied non-members, 8.8% of non-members said “always” satisfied and 19.5% of non-members said “often” satisfied, but 30% of non-members were “always” satisfied and 37.1% of non-members were “often” satisfied. A reasonable interpretation is that health co-ops provided more positive outcomes than 3 years prior.

Issues not covered by the survey

The survey was designed to examine the awareness of the integrated health care delivery system in South Korea. Health co-op users were included as survey participants because health co-ops mainly served as primary care facilities. Therefore, the survey focuses more on the health care process and patient satisfaction. The survey takes no account of the staff’s perspective on management and the operation of health co-ops.

Health co-ops have internal clubs and councils that are organized by the members. These are as important as the clinics. Residents can share the ownership by participating in the group activities that these organizations put on. The doctors in the clinics help the patients be cured, but it is up to the residents themselves to stay in good shape.

Chapter 5: Health Care Co-operatives in Other Countries

HEALTH CO-OPS IN JAPAN

Overview of Health and Welfare Co-operatives in Japan

Japan was the fourth country to actively form and manage co-operatives in 2010, following France, United States, and Germany. The total revenue of the co-operatives in Japan accounts for 8% of the country's gross domestic product (GDP; ICA, 2010). In the case of health co-ops, the Japanese Health and Welfare Co-operative Federation (JHWCF) had 111 member co-ops and represented 2,750,000 individual members in 2010. The staffs of the member co-ops amounted to 32,800 and its turnover was 602,798,985 Japanese Yen (JPY; approximately US$6 million). JHWCF managed 77 hospitals, 303 primary health care centers, 46 dentistry offices, 23 nursing care homes, and 183 helper stations (JHWCF, 2010).

Health co-ops in Japan are established based on the Consumers' Co-operative Law. The main business of the health co-ops are providing medical and nursing care services to local residents, and managing hospitals, primary health care centers, nursing care homes, home-visit care stations, rehabilitation facilities, at-home help services, and housing for elderly (JHWCF, 2010). The hospitals and clinics of health co-ops mainly provide primary and hospital care, and educational courses on learning self-diagnosis and prevention (Rodríguez, 2005). Most of the health co-ops set up 1,000 JPY (US$10) as share capital for a new member. Although the Consumers' Co-operative Law of Japan restricts services of co-ops to its members only, non-members can use, in case of health co-ops, services up to a half portion of the co-op's total business volume. Health co-ops,

however, strongly encourage non-members to join their organization and as a result, 80% of the health co-op users are members (JHWCF, 2010).

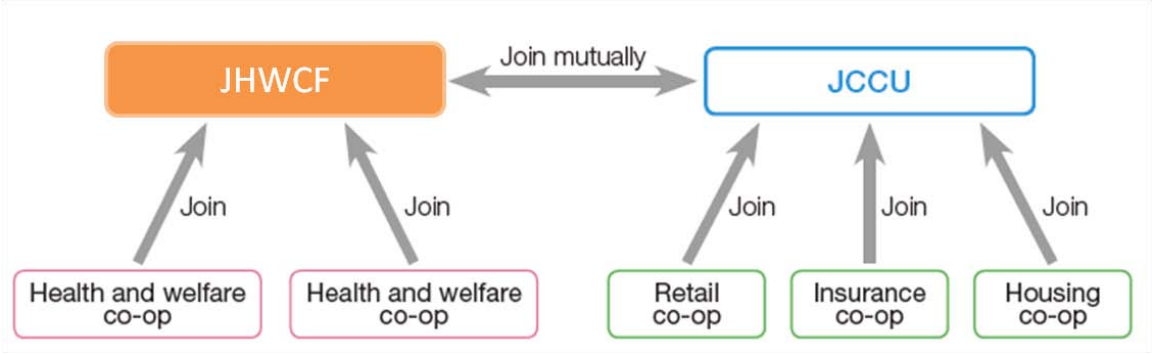
As they aim to provide medical services to local residents, health co-ops provide several benefits to their members. First, health co-ops provide some services at lower costs. As all citizens in Japan are registered to NHI, health care facilities in health co-ops basically provide medical and nursing care services covered by NHI. Of the several services such as health check-up and protective vaccination that are not covered by NHI, members pay at a discounted rate (JHWCF, 2010). Second, members can participate in various activities such as health checkup groups, volunteering, and health promotion activities. Most of the members, for example, organize and join small groups called *han*, and undertake self-health check activities such as the checking of blood pressure, somatic fat, and health practice (Rodríguez, 2005). The number of *han* groups are approximately 30 thousand nationwide, and 240 thousand members belong to *han* groups (JHWCF, 2010). Third, health co-ops provide health education opportunities which enable their members to become health advisors and thus become leaders in their communities (Kurimoto, 2005). Lastly, members have rights to participate in the operation of the health co-op. Under its democratic structure, health co-ops are operated based on members' opinions and concerns (JHWCF, 2010).

Partnership with other co-ops

Co-operatives in Japan are very actively formed and operated in communities. It is proved by the mutual membership between JHWCF and Japanese Consumers' Co-operative Union (JCCU), which is the National Federation of Consumer Co-operatives in Japan. The relation between the two is described in Figure 2. As JHWCF joins JCCU,

health co-ops indirectly become members of JCCU. And as JCCU joins JHWCF, these two organizations join each other (JHWCF, 2010). This mutual membership promotes partnerships between the different forms of co-operatives such as retail co-ops, insurance co-ops, or housing co-ops. The mutual membership is between the Foundation and the Union that enables the easier partnership; it does not mean a shared membership for individuals between the member co-ops. JCCU is engaged in several activities such as quality control of member co-ops' products, and supporting exchanges between the member co-ops and co-ops in overseas (ICA, 2008).

Figure 2: Relation between JHWCF and JCCU



Note. From *Relation between JHWCJ and JCCU, Japan, 2010*, Japanese Health and Welfare Co-operative Federation

HEALTH CO-OPS IN SPAIN

Integral health co-operative system

Health co-ops in Spain have a unique structure. Hospitals, health facilities, and insurance companies are operated by different co-operatives. For example, a consumer co-operative in Barcelona (170,000 members) owns a hospital. A worker co-operative of

doctors (5,000 doctors), also in Barcelona, owns a health insurance company and operates health facilities. And a third nation-wide co-operative of doctors (20,000 doctors) owns an insurance company and has the widest network of nonprofit hospitals and clinics in the country. The three co-operatives co-manage the health system of the organizations (Guisado del Toro, 2009).

In 1989, the three co-operatives created the Espriu Foundation, following the name of Dr. Joseph Espriu, who developed the co-operative health model. The foundation promotes the model by conducting research, organizing conferences and publishing resources. At the International Seminar on Healthcare and Co-operatives in 2005, which was sponsored by the Espriu Foundation, Marina Geli, the Catalan Government's Minister of Health pointed out that the major challenges of the integral health co-operative model would be engaging community members to participate in the public healthcare system (Rodríguez, 2005).

Furthermore, health co-ops in Spain have public-private partnerships on a large scale. First, the government's support is channeled through various levels. The national-level relationships are firmly formed with an association of foundations (the Asociación Española de Fundaciones), a federation of consumer co-operatives (the Federación Co-operatives de Consumo de Cataluña), and affiliates of the International Center of Research and Information on the Public, Social and Co-operative Economy (Guisado del Toro, 2009). Second, social economy organizations such as the International Health Co-operative Organization, an occupational organization of the International Co-operative Alliance, the International Labor Organization, and the World Health Organization (WHO) are included in the health co-ops framework (Rodríguez, 2005).

In sum, health co-ops and social economy organizations play important roles in the health care delivery system. Specifically, they represent a convergence of public and private market-based health care delivery (Guisado del Toro, 2009).

HEALTH CO-OPS IN CANADA

Overview of Health Co-ops in Canada

The co-operative movement in Canada has a long history, about 70 years worth. The first health co-op, Services de santé de Québec (SSQ), was established in Quebec City in 1944, and now serves the entire province of Québec (Panayotof-Schaan, 2009). The first health insurance co-op in British Columbia, CU&C Health Services Society, was incorporated in 1946. Although it aimed at providing prepaid medical insurance plans at a low cost, it is no longer operating as it merged with the Medical Services Association to form the Pacific Blue Cross in 1997 (Craddock, 2004).

There are over 101 health co-ops that serve over 1 million people across the country (MacKay, 2007). Health co-ops include community health centers, health clinics and hospitals, paramedics' co-ops, and home care co-ops. Notably, the number of home care co-ops is high. In 2004, 52% of health co-ops were home care co-ops; 15% were health clinic and hospital co-ops; 7% were ambulance co-ops; the rest were other health related (Craddock, 2004). When a co-operative wants to cover a single province for its service area, it must be incorporated and registered with a provincial government. If it operates in more than one province, it is registered under federal legislation. Co-operatives in British Columbia, for example, register based on the British Columbia Co-operatives Association Act (Panayotof-Schaan, 2009).

The five main sources of funding for health co-ops are: membership fees, rent from health care providers, payments by patients who utilize services not covered by Canada Health Act, grants from third parties, and government grants. The third parties include other co-operatives, credit unions, economic development organizations, and charitable organizations (Panayotof-Schaan, 2009).

Potentials and Challenges of Health Co-ops in Canada

Health co-ops in Canada are known for their cost-effective, responsive, patient-centered health care delivery. In health co-ops, physicians and other health professionals focus on health prevention and promotion. And the patient-member structure of health co-ops helps build both healthy populations and healthy communities through member decision making, activism, and empowerment (MacKay, 2007). In addition, Angus & Manga (1990) showed that medical costs per patient were 17% lower than fee-for-service, hospitalization rates were up to 30% lower, and 21% less money was spent on prescription drugs in health co-ops.

Health co-ops sometimes function as a lobbying group in the health care system. In 1962, for example, 90% of doctors protested the first introduction of Canada's universal health care system by closing their offices. As a result of this strike, the doctors earned the right to form a rate plan in their favor. In opposition to this group, a group of concerned, pro-medicare citizens and doctors established a health co-op called the Community Health Services Association Ltd (Panayotof-Schaan, 2009). Health co-ops cannot impose conditions on services governed by the Canada Health Act, but they work to improve access to some services such as home care options for the elderly and disabled (HCCFC, n.d.).

Despite the benefits and the potentials of health co-ops in general, health co-ops in Canada, especially those in British Columbia face a big challenge: lack of physicians. Only two out of eight health co-ops in the province currently provide health services and rest of them are still under preparation or are not currently providing services (MacKay, 2007). Even the two health co-ops operate without physicians and provide other health services such as home care, nursing services. It is due to the lack of appropriate funding sources to operate clinics under the fee-for-service system (MacKay, 2007). In this case, governments' support is a critical issue for the success of health co-ops. In the province of Saskatoon, for example, the province government finally recognized that health co-ops have succeeded in meeting the health care needs instead of the governments and now funds the Saskatoon Community Clinic, which the Saskatoon health co-op operates (MacKay, 2007).

Chapter 6: Conclusions and Recommendations

CONCLUSIONS

In conclusion, health co-ops may not be able to substitute for the primary health care system in South Korea; however, they should be able to complement the system well. The idea of establishing a health co-op may not be familiar to many parts of South Korea. Its history with the co-operative movement is shorter than that of other countries. The number of registered health co-ops is small and mainly concentrated in Seoul's greater metropolitan area. Hence, many Koreans are unaware of their presence. The biggest health co-op serves fewer than 5,000 households in a mid-sized city, and the four smallest health co-ops just started to provide their services to about 300 households each. Considering, however, the development of not only health co-ops but also other co-operatives in South Korea as a whole the future of the health co-op is now much brighter than it was just five years ago.

First, health co-ops benefit not only their members but also the communities. As health co-op clinics are allowed to treat non-members in the communities, having the clinics in a community increases the access to affordable health care services for residents. Health co-ops provide plenty of opportunities for their members to get involved, develop themselves, and volunteer in communities. Along with the shared ownership, doctors have less stress on managing clinics, and it enables them to focus more on patient-centered treatment.

Second, based on the results of the surveys and interviews, it can be concluded health co-ops are so far functioning well. Members tend to get fewer unnecessary

repeated treatments; they are more likely to feel their doctors discuss the checkup results further with them; and they think their doctors better understand their needs. The small groups of people gathered under the name of health co-ops are very satisfied with the health care services they receive. The degree of awareness and satisfaction increased from 2009 to 2012.

Third, the government support of health co-ops is one of the key factors for the success. Recently, the support of governments in South Korea has increased. The revised Consumer Co-operative Act and legislated Basic Law on the Co-operatives support the much easier operation of health co-ops both legally and financially than before. One of the pledges of the Bak administration is fostering co-operatives, and they expect co-operatives can also increase job opportunities and welfare in communities. As the 111 health co-ops in Japan employ more than 32,800 individuals for full time positions (JHWCF, 2010), supporting health co-ops is expected to increase job opportunities in South Korea as well. However, the government should approach more carefully by developing comprehensive strategies to support co-ops, rather than dreaming a rosy future, because a failure of a co-op means the lost of not only the job but also the investments for an employed member (Um & Shin, 2012).

RECOMMENDATIONS

To function as alternatives to the health care system in South Korea, health co-ops must overcome some difficulties. What precisely is meant by alternative? The word means a new system or value that is able to substitute or replace the current system or framework, when the current system causes serious problems to the society. And the core value of the health co-op is, as the name implies, cooperation. Health co-ops should

develop more effective ways of getting more people actively involved, to hire more doctors, to secure funds for stable management.

First, to increase awareness of these co-ops, more education is needed. It is important to engage people to actually participate and do their part. The key factor that decides the success of a health co-op depends upon how well the members understand the principles of co-ops and how much they are willing to participate together. It is very difficult to get members to actively participate in the organization. Especially in the preparation stage, people can, without actively participating, just wait for the health co-op to be established and expect to receive benefits by visiting the clinics and getting medical services. It is important to engage people by instilling in them the mindset, “It is impossible without me.” It is then encouraging that most of the health co-ops run clubs studying co-operatives.

Second, to attract more medical personnel, co-ops need to develop more attractive benefits for them. Working in a health co-op may be more worthwhile for doctors personally, as it generally includes more social value. However, it is not enough to change the behavior of people. A doctor currently working in a health co-op says that, while they get paid less, their financial burden is much lighter to that of other doctors running their own hospitals. Every member of a Co-op shares the ownership and responsibility. Japan offers students a wide range of scholarships funded by health co-op associations, and substantial numbers of recipients join health co-ops after they graduate.

Third, studies with comprehensive analyses are recommended. The survey used in this report was originally conducted in order to examine the awareness of the integrated health care delivery system in South Korea. Future studies might take the view of the management side, such as finding the relationship between the level of participation of members and their satisfaction and quality of life. Other related parts, such as members’

participation and staff's management are also worthy of consideration. Furthermore, these studies should provide evidence of effectiveness of health co-ops for the government to consider more support.

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